Automation and Analytics to Improve Quality and Safely Reduce Hospitalizations:

The Advancing Excellence Campaign

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Long Term and Post Acute Care
LTPAC HIT
Health IT Summit ■ ahima.org/ltpacsummit

#LTPAC13

What is Advancing Excellence (AE)?

- An ongoing campaign to help nursing homes (NHs) become high performance organizations
- Includes staff and consumers as valued partners
- Voluntary (>59% or 9,355 NHs registered)
- Based on measureable improvement of meaningful goals
- Carefully aligned with other national QI initiatives
- Campaign relies on IT for
  - Registration for the campaign
  - Access to free educational materials and analytic tools
  - Tracking trends and comparing outcomes

How Advancing Excellence is Structured?

Board of Directors

- Sets Goals
- Develops Resources
- Provides Support

Statewide LANE*

- Recruits nursing homes
- Coordinates statewide activities
- Provides support
- Conducts state level improvement activities

Nursing Home

- Registers for AE
- Selects and works on at least 2 goals
- Enters data on website
- Uses Campaign's web-based resources for QAPI

*LANEs are state level coalitions of key stakeholders. Core members include: provider associations, QIO, Survey Agency and ombudsman

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9 Goal Topics:
5 are clinical and 4 are "process"

Hospitalizations	Staff Stability	Pressure Ulcers
Medications *Antipsychotics*	Consistent Assignment	Infections *C. difficile*
Mobility	Person-Centered Care	Pain Management

Clinical Goal Measures

- Anti-psychotic (APs) medications:
  - % of Residents on
    - PRN APs or
    - Scheduled and PRN APs
  - % of residents on APs for dementia with associated behavioral symptoms
  - % of residents on multiple APs
  - % of residents who underwent a gradual dose reduction
- Mobility:
  - % residents with improvement in personal movement
  - % residents with improvement in life space mobility
- Infections: Clostridium difficile
  - CDI NH-onset incidence rate/10,000 resident days
  - Prevalence of treated CDI on admission
- Pressure ulcers (PU):
  - % of Residents with PU
  - % of PU that are NH Acquired
  - % PU that are Community Acquired
- Pain:
  - % Residents with a Pain Assessment Each Week During this Month
  - Average Weekly % of Residents Reporting Moderate or Severe Pain
  - Average Weekly % of Residents with Pharmacologic Interventions for Pain
  - Average Weekly % of Residents with non-Pharmacologic Interventions for Pain
  - Average Weekly % of Residents with Pharmacologic and non-Pharmacologic Interventions for Pain

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Process Goal Measures

- **Hospitalizations:**

- <u>outcome measures*</u>:

  - **30-day Readmission Rate as percent of those admitted from a hospital during the month**
  - **Hospital Admission Rate per 1000 resident days this month**
  - **Rate of Transfers to ER Only per 1000 resident days this month**
  - **Rate of Transfers Resulting in Observation Stay per 1000 resident days this month**

- <u>process measures</u>: help answer the "why" question – homes can see patterns (e.g. day of week, physician practices, ignored resident preferences) that show where problems lie.

- **Staff Stability:**
  - **CNA or RN or LPN/Overall Turnover**
- **Consistent Assignment:**
  - **% of Residents with 12 or Fewer CNA's caring for them in the measurement period**
- **Person-centered Care: 2 components**
  - **Congruence of resident-reported "importance" vs "frequency" of activities identified in MDS Section F**
  - **Composite score based on resident, family & direct care staff participation in care planning process**

***The rate calculations are consistent with the proposed CMS quality measure for SNF 30-day readmissions as of 12/12**

Advancing Excellence Home Page

LTPAC HIT

HOME | ABOUT THE CAMPAIGN | RESOURCES | PROGRESS | FOR PARTICIPANTS

- Getting Started
- Explore Goals
- **Process Goals:**
  - Consistent Assignment
  - Hospitalizations
  - Person Centered Care
  - Staff Stability
- **Clinical Outcome Goals:**
  - Infections
  - Medications
  - Mobility
  - Pain
  - Pressure Ulcers

The New Goals

They're here!

Nine new goals and fresh resources are now available to support your quality improvement projects.

Getting Started guides you through your quality improvement process and illustrates how the new goals and resources drive each step.

Ready...Set...Go!

Explore the goals and the available resources by clicking in the grid below.

Register or

update your profile

before you select new goals.

Select goals

to be a registered participant. You must select at least one process goal AND one clinical outcome goal.

Which Resources Are Currently Available?

Process Goals	Explore Goal	Identify Baseline	Examine Process	Improve	Leader-ship	Monitor & Sustain	Celebrate
Consistent Assignment	Go!	Go!	Go!	Go!	Go!		

Data and the Quality Improvement (QI) Process

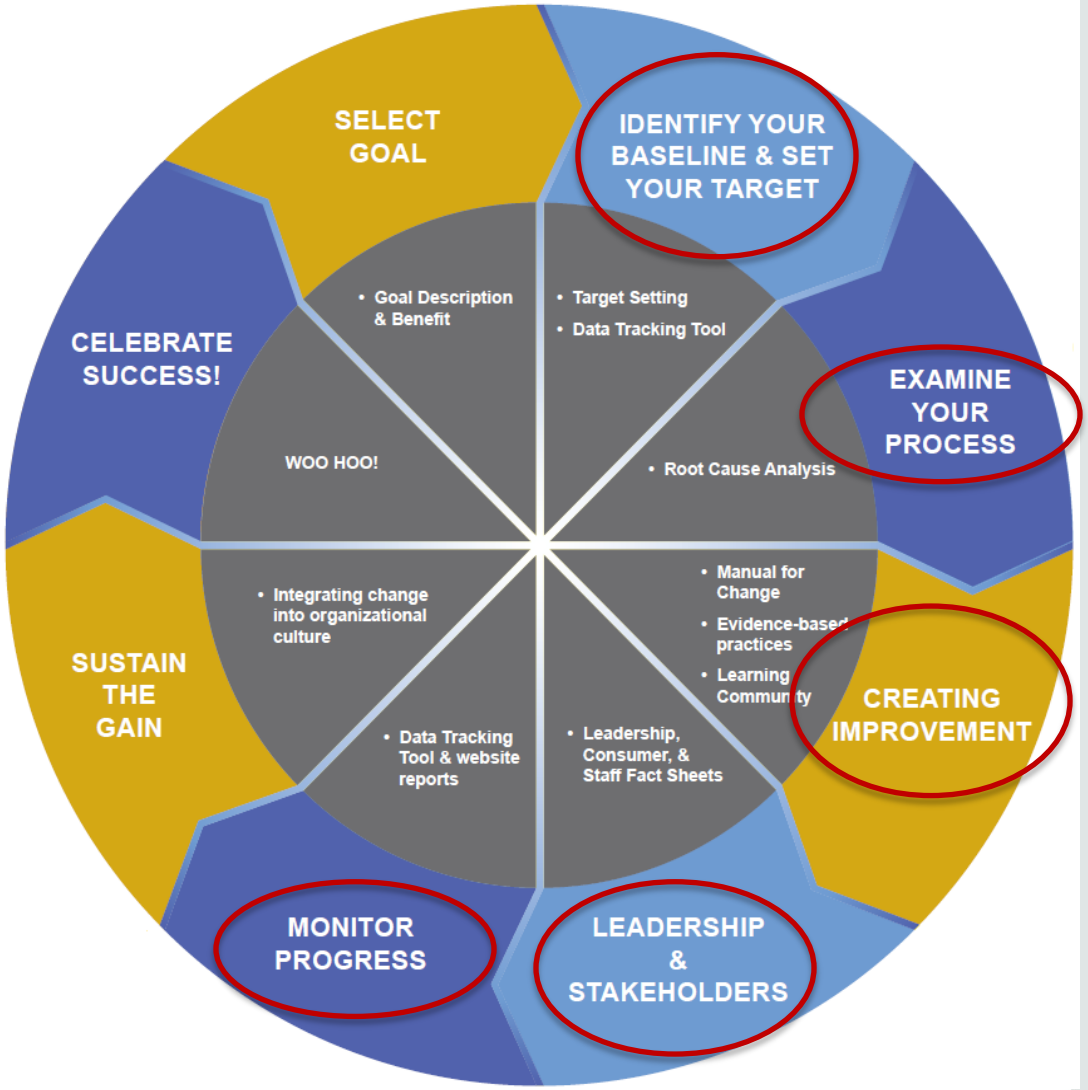
How do I know where I am?

Where do I want to be?

What processes are associated with my outcome?

When I change a process, how do I know it had the effect I wanted?

How am I doing compared to other nursing homes working on this goal?



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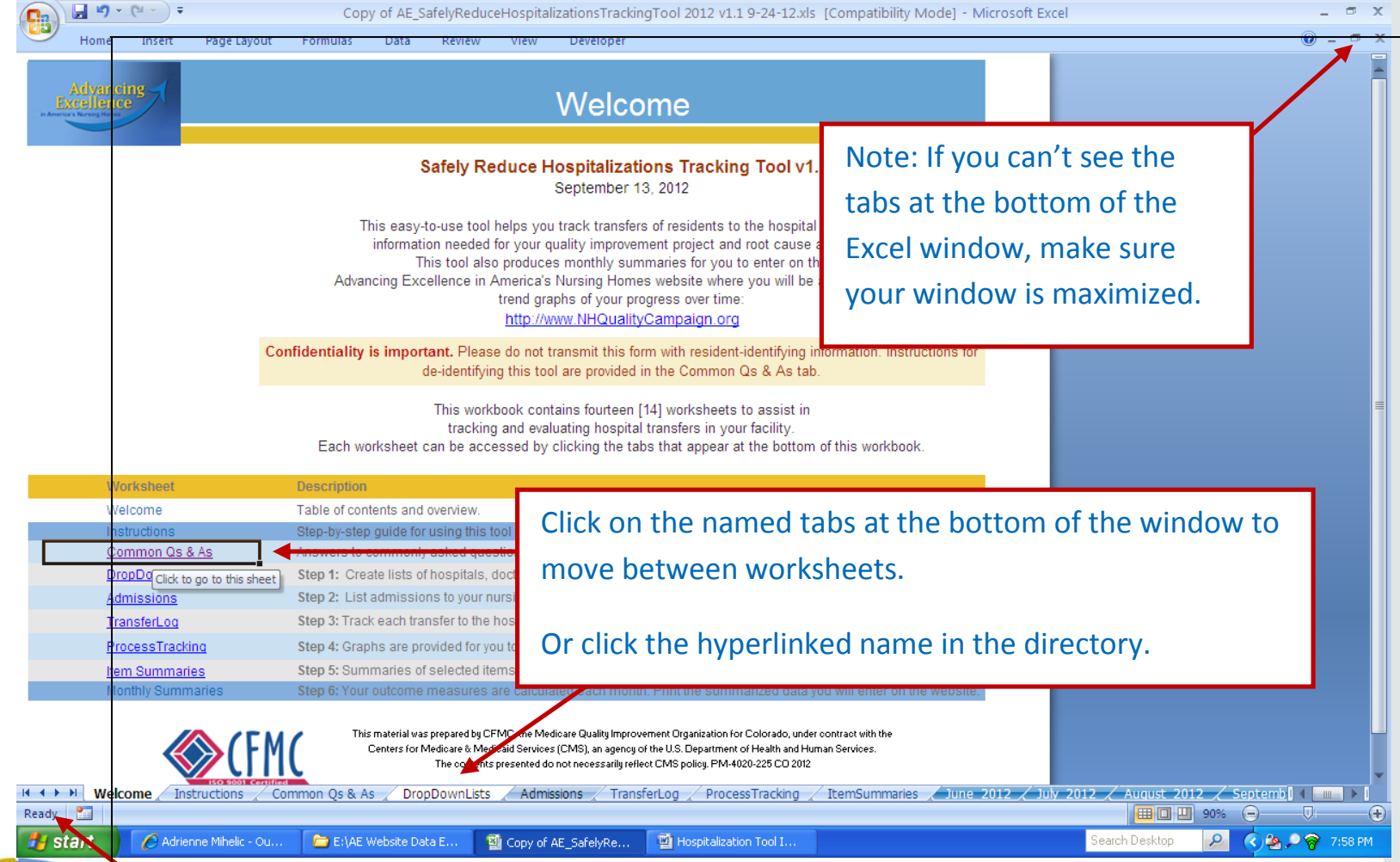
Tracking Tools:
Support both QA and PI

- Easy view of **individual** records allows resident-level RCA of events
- Matrix of individual data allows scanning for **patterns**
- Summary information helps identify opportunities to improve communication and optimize processes at the **system** level

AE's Hospitalizations Measures

- Outcome measures*:
  - 30-day Readmission Rate as percent of those admitted from a hospital during the month
  - Hospital Admission Rate per 1000 resident days this month
  - Rate of Transfers to ER Only per 1000 resident days this month
  - Rate of Transfers Resulting in Observation Stay per 1000 resident days this month
- Process measures: help answer the "why" question – homes can see patterns (e.g. day of week, physician idiosyncrasies, communication breakdowns) that may show where the problems are.

*The rate calculations are consistent with the proposed CMS quality measure for SNF 30-day readmissions as of December, 2012



Note: If you can't see the tabs at the bottom of the Excel window, make sure your window is maximized.

Click on the named tabs at the bottom of the window to move between worksheets.

Or click the hyperlinked name in the directory.

Sometimes there are so many worksheets in your workbook that you can't see them all. Use the scroll bar on the LEFT side of the window to see all tabs.

Transfer Log

Step 4: Complete the detail for each resident transferred from your nursing home to hospital in the grid below.

Highlight indicates resident had an unplanned admission to the hospital within 30 days of discharge from hospital. Not all transfers result in admission.

Include ONLY transfers to acute care hospitals or critical access hospitals

*Red asterisk indicates required field.

	About this Resident			About this Transfer						
	How to Use							How to Use		
	Automatic Resident Code to de-identify your file	Resident Name* example: Jane Brown	Purpose of Nursing Home Stay* Post-acute Type Care / Chronic Long Term Care	Payment Status at Time of Transfer from Nursing Home to Hospital select from list	Date of Transfer to Hospital* example: 7/21/12	Transfer: Time of Day select from list	Clinician Ordering Transfer	Automatic Clinician Code to de-identify your file	Primary CLINICAL Reason for Transfer	Primary CONTRIBUTING Reason
1										
2										
3										
4										
5										
6										
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11										
12										
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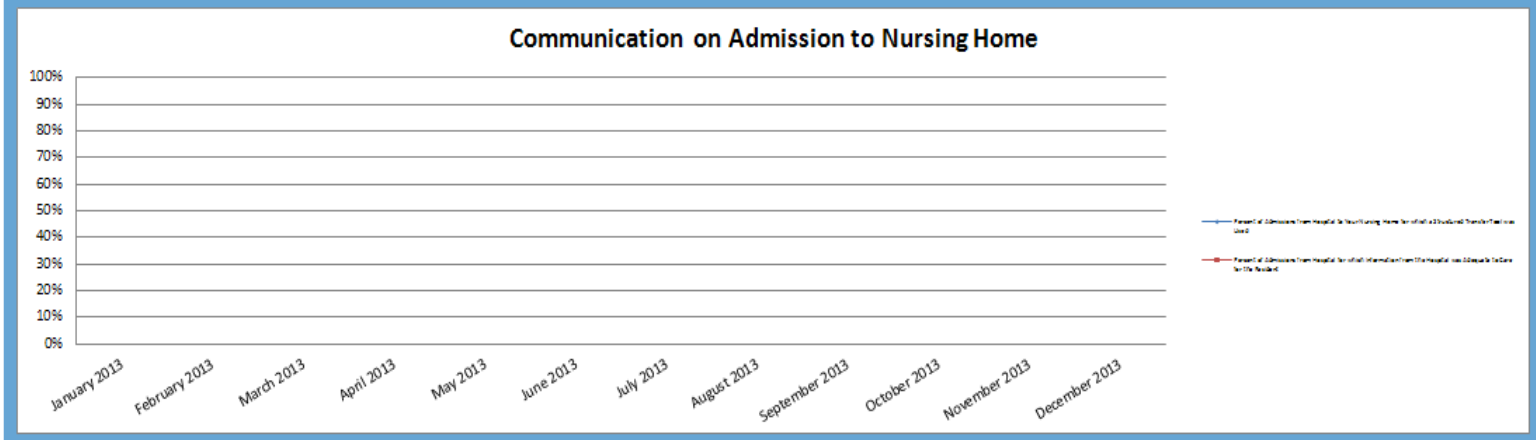
27										

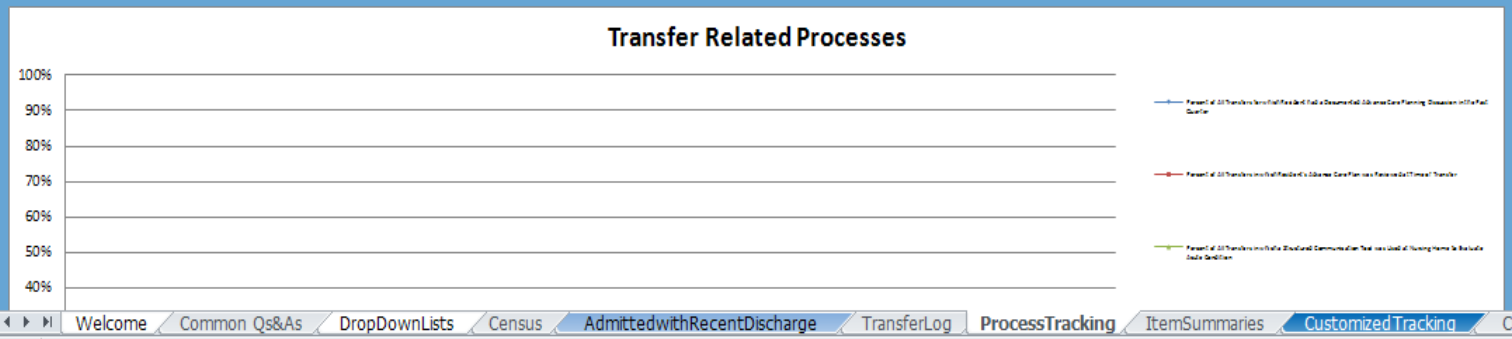
Resident's Name
Select from dropdown list or enter name exactly as it appears on the drop down list.

Welcome | Common Qs&As | DropDownLists | Census | AdmittedwithRecentDischarge | TransferLog | ProcessTracking | ItemSummaries | CustomizedTracking | CustomizedItemSummaries | January 2013 | February 2013

Process Tracking



Measures	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13
Total Admissions	0	0	0	0	0	0	0	0	0	0	0	0
Percent of Admissions from Hospital to Your Nursing Home for which a Structured Transfer Tool was Used												
Percent of Admissions from Hospital for which Information from the Hospital was Adequate to Care for the Resident												



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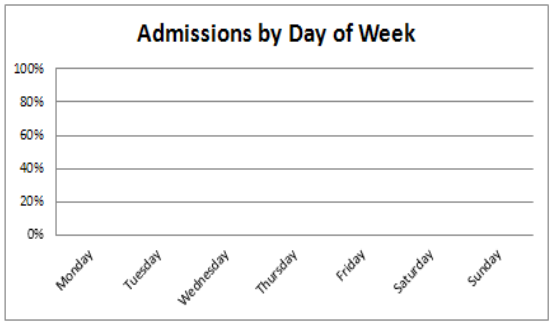
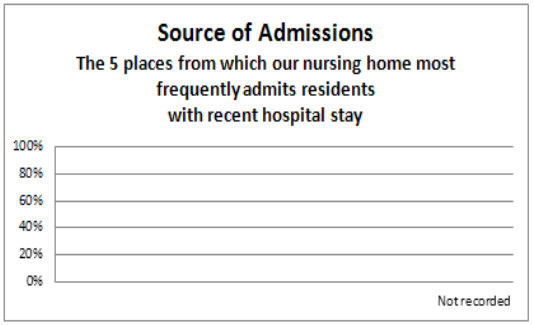
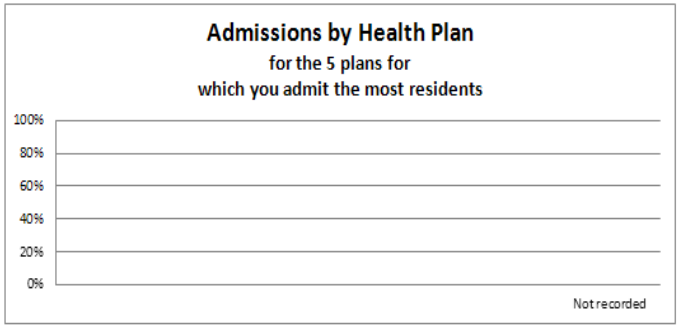
Item Summaries Page

Admissions Detail
Year-to-Date







Admissions by Day of Week

	Number of Admissions	Percent of all Admissions
Monday	0	n/a
Tuesday	0	n/a
Wednesday	0	n/a
Thursday	0	n/a
Friday	0	n/a
Saturday	0	n/a
Sunday	0	n/a

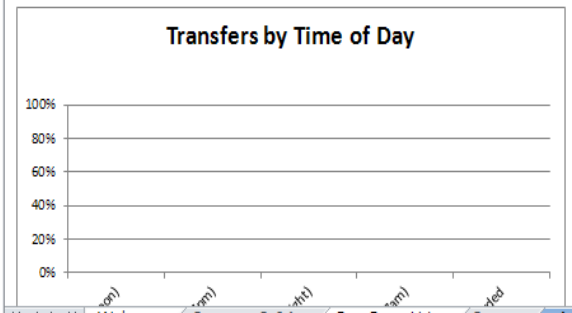
Source of Admissions
for the five places from which our nursing home most frequently admits residents with recent hospital stay

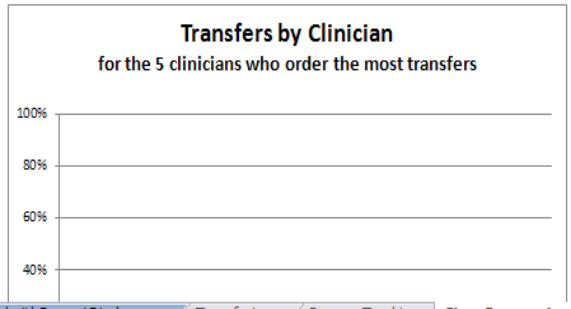
	Number of Admissions	Percent of all Admissions
		n/a
		n/a
		n/a
		n/a
		n/a
Not recorded	0	n/a

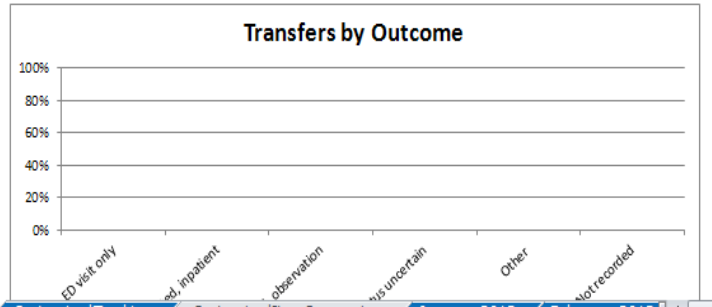
Admissions by Health Plan
for the five plans for which our nursing home most frequently admits residents

	Admissions	Admissions
		n/a
		n/a
		n/a
		n/a
		n/a
Not recorded	0	n/a

Transfer Detail
Year-to-Date







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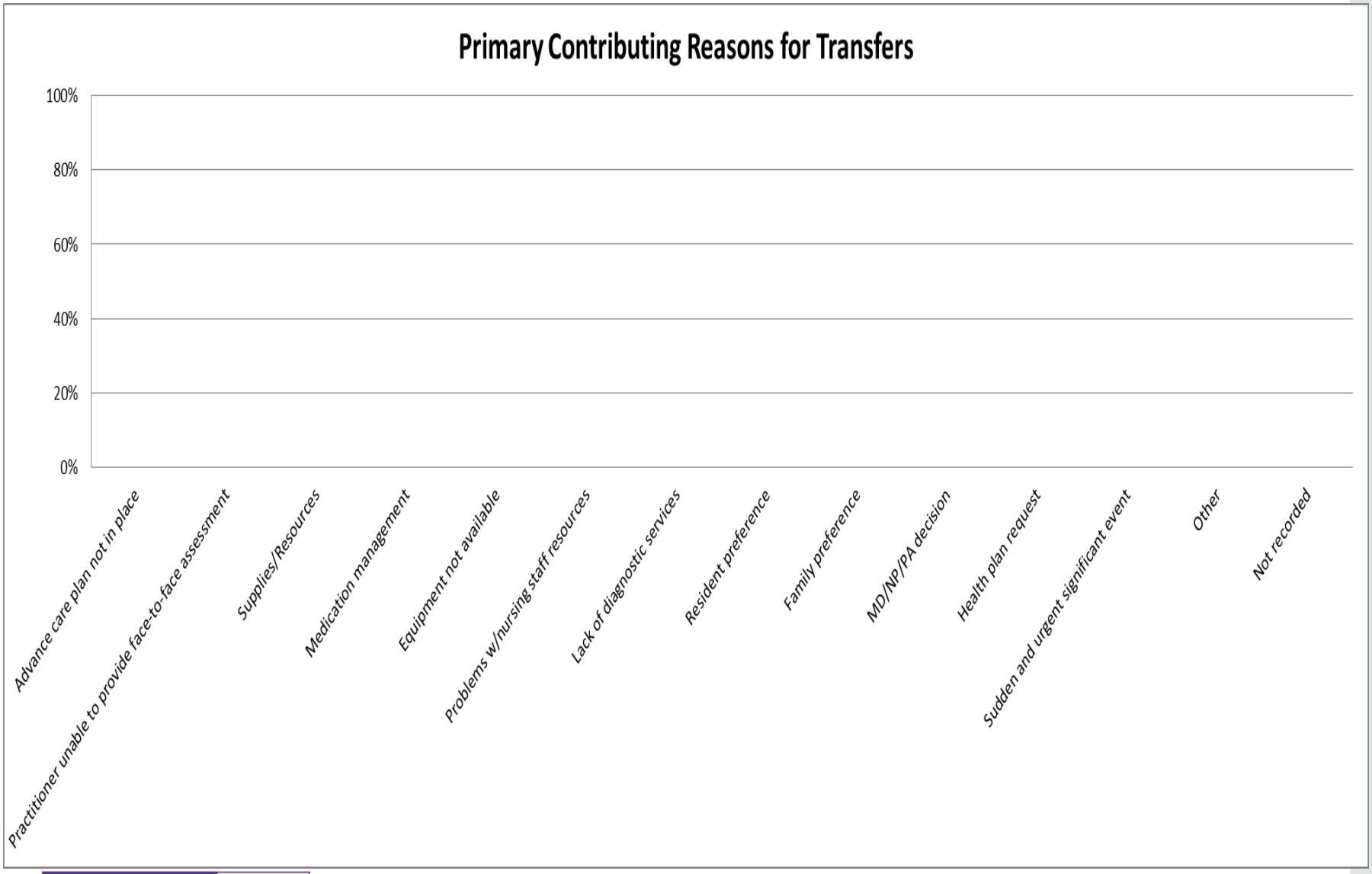
Reasons for transfer go beyond clinical condition



Hospitalizations Resource List

Process Goals:
- Consistent Assignment
- Hospitalizations
- Person Centered Care
- Staff Stability

Clinical Outcome Goals:
- Infections
- Medications
- Mobility
- Pain
- Pressure Ulcers

Explore Goal | Identify Baseline | Examine Process | **Improve** | Leadership | Monitor & Sustain | Celebrate

In addition to using a PDSA cycle to create change, the AE Campaign has identified best practices to help you get started.

Recognition

INTERACT II Stop and Watch Early Warning Tool
INTERACT Stop and Watch, designed for use by all staff and family members provides a way recognize early warning signs of changes in resident condition that need clinical follow-up.

INTERACT II Care Paths and Change in Condition File Cards
INTERACT Care Paths and Change in Condition File Cards assist nurses in making judgments about changes in resident condition and what issues need immediate and non-immediate intervention by the physician.

Communication

INTERACT II Acute Care Transfer Document Checklist
INTERACT Acute Care Document Checklist identifies and organized the information that needs to be sent to the hospital when a hospital transfer is needed.

Pioneer Network Shift Huddle Tip Sheet
Pioneer Network Shift Huddle Tip Sheet describes how to set-up and conduct Shift Huddles to communicate change in condition information across shifts.

CHATS - Communicating Health Assessment by Telephone | CHATs Progress Note
CHATs – Communicating Health Assessment by Telephone are tools consisting of 16 common problems found in long term care settings. Tools are used by clinical staff in reporting change in condition.

Research study of implementation of CHATs in LTC Facility
Detailed description of Duke University and Durham VA Extended Care & Rehabilitation Center project improving nurse/physician communications using CHATs.

Advanced Care

INTERACT II Advanced Care Planning Tools
INTERACT tools to help manage residents at or near end-of-life. Tools include: Resident at High Risk for Entering the Active Dying Process, Advanced Care Planning Tips for Starting and Conducting the Conversation, Communication Tips, Helpful Language for Discussing End-of-Life, Examples of Comfort Care Interventions, Advanced Care Planning Tracking Form.

Process

LTC Professional Leadership Council Care Delivery Process (2008)
LTC Professional Leadership Council describes the universally acknowledge method to identify and address complex issues to enable individualized care plans and interventions.

COST INFORMATION FOR NURSING HOME RESIDENTS WHO FACE HOSPITALIZATION

GOAL:

This information is aimed at explaining to nursing home residents and their families two cost related issues they may want to ask about if the resident has to go to the hospital.

1. What is the nursing home's "bed hold" policy?
2. What kind of stay will the resident have in the hospital? Is it an "inpatient admission" or an "observational stay"?

BED HOLD POLICY

Sometimes a resident has to leave the nursing home for a day or two to be treated at a hospital. It's important to ask whether or not the resident's nursing home bed will be saved for his or her return. This answer may vary depending on how the resident is paying for his/her care. If the stay in the nursing home is being paid for by...

- Medicaid: State and Federal laws give the resident the right to return to the first available nursing home bed after hospitalization. Many states specify how many days a nursing home must hold a bed for the resident and for those covered by Medicaid, the number of days cannot be less than the state requirement. Before a resident on Medicaid is hospitalized, the nursing home must give the resident and a family member or legal representative written information describing its bed hold policy and the resident's right to return to the first available bed[1]. IF THE RESIDENT EXCEEDS THE TIME SPECIFIED IN THE "BED HOLD" POLICY AND DOESN'T PAY THE HOME FOR ADDITIONAL DAYS OUT-OF-POCKET, the resident may be temporarily admitted to another nursing home. They are able to then) the first available bed at the original nursing home if they so choose.

nsurance: Check the insurance policy to see what it will pay for. Each policy is different. Some may not pay to hold the nursing home bed for the resident. In that case, the resident or his/her family may have to out- t to hold the bed if the resident wants to return to a particular nursing home.

ay (or out-of-pocket): If the resident or his or her family is paying directly for the resident's care and wants k to that same nursing home after going to the hospital, they will most likely have to continue to pay the ome its daily rate while the resident is in the hospital. Ask the nursing home what its specific policies are.

What health related services can my nursing home provide?

A questionnaire to help families and residents talk to nursing homes

When a resident of a nursing home suddenly gets sick they may need certain types of care or services not routinely provided in the nursing home. Following are questions consumers can ask about services a nursing home might offer in these situations. Don't wait for an emergency – know in advance what the NH can provide because not all nursing homes will have everything listed here. Once you know, it will be easier to decide whether or not the resident can be safely cared for without going to the hospital.

- Is there someone on site at all times who has been trained and is certified to perform basic cardio-pulmonary resuscitation (CPR)? Are automatic defibrillators present? Not all residents may want to have resuscitation. But for those that do, it should only be given by people who have completed the required training course.
- What tests can be done in the nursing home? Within what time frame should results be available? Examples include:
  - Electrocardiogram (EKG) – should be within 4-6 hours
  - Chest X-ray (CXR) – should be within 4-6 hours
  - Laboratory tests, such as blood work – should be within 4-6 hours
  - o Bladder ultrasound to determine if urine is being retained
  - o Venous Doppler test to detect blood clots in the leg
- How often is a doctor, nurse practitioner, or physician assistant present on site? (should be at least once or twice a week)
- What kind of specialty consultants come to the nursing home?
  - o Psychiatry?
  - o Wound care specialists?
  - o Other medical or surgical specialists?
- When a new medicine is ordered, how long is it before it can be given to the resident? For example, if a resident has pneumonia and the doctor orders an antibiotic can it be started within 4 hours?

Why is Advancing Excellence so important?

- **Intentionally designed to encourage homes to use the internet as a portal to quality improvement resources**
- Data drives improvement
  - Each goal has a way to calculate baseline and measure improvement
  - The measures are standardized across providers and states
    - NHs can compare their performance to state and national benchmarks
    - Payers and other providers can compare NHs before developing preferred provider agreements or to improve transitions
  - New measures for assessing quality can be tested
- Targets workforce factors (e.g. turnover), personal preferences and other clinical issues which have to be part of safely reducing hospitalizations
- A natural experiment? Could compare homes in CMS's *Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents* and those that are doing it only with AE or INTERACT
- Resident identifiers can be redacted so data collection tools can be shared among providers for learning purposes.

Thank you

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